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ARTIGO DE INVESTIGAÇÃO (ORIGINAL)

Attention foci in community health nursing and community empowerment: a qualitative study

Os focos de atenção em enfermagem comunitária e o empoderamento comunitário: um estudo qualitativo

Los focos de atención en enfermería comunitaria y el empoderamiento comunitario: un estudio cualitativo

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Abstract

Background: Community empowerment constitutes a specific skill of the nurse specialist in community nursing and must be employed in their clinical decision-making.
Objectives: To identify the attention foci of nurses who develop community intervention, considering the community as a care unit.
Methodology: Qualitative study through focus group technique. Data were analyzed using content analysis technique. The categories system was based on the Continuous Community Empowerment Model of Laverack (2005). A categories system for data analysis was established, based on the foci of the International Classification for Nursing Practice (version 2.0).
Results: A main nursing focus associated with community empowerment was identified (community management) and 3 foci integrated as diagnostic dimensions of the main focus (community participation, community process, and community leadership).
Conclusion: Attention areas that promote nurses' clinical decision-making associated with community empowerment were identified. There are foci in community health nursing related to community empowerment, which provide an identity process based on the competences of this specialty area.

Keywords: community health nursing; nursing diagnosis; empowerment; community participation; focus groups

Resumo

Enquadramento: A capacitação de comunidades, enquanto competência específica do especialista em enfermagem comunitária, remete para o empoderamento comunitário.
Objetivos: Identificar os focos de atenção dos enfermeiros que desenvolvem intervenção comunitária, considerando a comunidade como unidade de cuidados.
Metodologia: Estudo de natureza qualitativa desenvolvido através da técnica de grupos focais. Os dados foram analisados recorrendo-se à técnica de análise de conteúdo. O sistema de categorias sustentou-se no Modelo Contínuo de Empoderamento Comunitário de Laverack (2005). Foi estabelecido um sistema de categorias para a análise dos dados, sustentado nos focos da Classificação Internacional para a Prática de Enfermagem (versão 2.0).
Resultados: Identificou-se 1 foco de enfermagem principal associado ao empoderamento comunitário (gestão comunitária) e 3 focos integrados como dimensões de diagnóstico do foco principal (participação comunitária, processo comunitário e liderança comunitária).
Conclusão: Identificaram-se áreas de atenção que potenciam a tomada de decisão clínica dos enfermeiros associada ao empoderamento comunitário. Existem focos em enfermagem comunitária, relacionados com o empoderamento comunitário, conferindo um processo identitário alicerçado às competências desta área de especialidade.

Palavras-chave: enfermagem em saúde comunitária; diagnóstico de enfermagem; empoderamento; participação comunitária; grupos focais

Resumen

Marco contextual: La capacitación de comunidades, como competencia específica del especialista en enfermería comunitaria, se refiere al empoderamiento comunitario.
Objetivos: Identificar los focos de atención de los enfermeros que desarrollan intervenciones comunitarias, considerando la comunidad como unidad de cuidados.
Metodología: Estudio de naturaleza cualitativa desarrollado a través de la técnica de grupos focales. Los datos se analizaron con la técnica de análisis de contenido. El sistema de categorías se basó en el Modelo Continuo de Empoderamiento Comunitario de Laverack (2005). Se estableció un sistema de categorías para el análisis de los datos de acuerdo con los focos de la Clasificación Internacional para la Práctica de Enfermería (versión 2.0).
Resultados: Se identificó 1 foco de enfermería principal asociado al empoderamiento comunitario (gestión comunitaria) y 3 focos integrados como dimensiones de diagnóstico del foco principal (participación comunitaria, proceso comunitario y liderazgo comunitario).
Conclusión: Se identificaron áreas de atención que potencian la toma de decisiones clínicas de los enfermeros asociadas al empoderamiento comunitario. Existen focos en enfermería comunitaria relacionados con el empoderamiento comunitario, lo que aporta un proceso identitario basado en las competencias de esta área de especialidad.

Palabras clave: enfermería en salud comunitaria; diagnóstico de enfermería; empoderamiento; participación comunitaria; grupos focales

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Introduction

Community empowerment (CE) is a concept studied since 1980 and has been addressed either as a process or as a result by several authors (Gibbon, Labonté, & Laverack, 2002; Israel, Checkoway, Schulz, & Zimmerman, 1994; Rappaport, 1981). There is a consensus of opinion that it is linked to the community members' participation, their cohesion, and improving their ability to identify and solve their problems in a way mainly autonomous of external agents (Laverack, 2005). Regarding the perspective of CE as a process, Laverack in 2005 defines a continuous model that allows us to frame the CE in five domains: a) personal action related to the development of individual perception of belonging and of value so the person can participate in their community with the purpose of solving their issues; b) the approach of small community groups, associated with the involvement of groups of people with identical characteristics, goals and identity, in order to increase, collectively speaking, their perceptions of importance for the identification and resolution of problems in the community; (c) the development of community organizations, as a result of the intentional interaction of small groups, to set up difference-based common goals which strengthen the community as a whole; d) the establishment of intra- and intercommunities that promote growth and profitability of resources to identify and solve the problems of the community; (e) the social and political action, the stage in which a framework of policies and macrosystemic action is established as a result of the consolidation of community organizations and their partnerships, while perpetuating an ideal environment for the CE maintenance (Laverack, 2005).

Community health nursing is a specialized field of the nursing profession and one of its main competences is community training (República Portuguesa, 2018), whose definition fits the CE concept. Following the assumptions of Silva (2007), the advanced approach of nursing, conducted by the Nurse Specialist in Nursing Community (*Enfermeiro Especialista em Enfermagem Comunitária* - EEEC), should fulfill decision-making based on specific competencies of this specialty field, that is, decision-making oriented towards the community as a unit of care. This decision-making should also take into account the use of a nursing theoretical framework in order to organize clinical decision-making, so that community empowerment could be identified as a process and as a result of the intervention of this nurse specialist. We seek to respond to conceptual framework of a community-oriented nursing model, through the actors who experience the clinical decision-making processes, as similar recent studies have identified, for instance, for the family health field (Temido, Craveiro, & Dussault, 2015), seeking to identify, within the context of clinical decision-making in nursing, the attention foci of nurses, when the community is their health care target.

Background

A nursing theory, being a set of interrelated concepts, assumptions, and definitions, allows systematizing the look and the thought to facts and events associated with the discipline, so that the nursing care can be described, explained, predicted and prescribed (Alligood, 2014). To understand the levels of concept and study of the nursing discipline, the nursing theories detect, in their more abstract level of knowledge, the metaparadigm, composed by the concepts of person, environment, health, and nursing care (Alligood, 2014). The models, from which the theories are born, represent the structuring of reality of the nursing discipline. They allow organizing, understanding, and giving meaning to a nursing-based reality (Alligood, 2014).

The analysis of nursing models and theories in the different schools where the discipline is developed finds models and theories based on the *individual person*, in which the groups, such as the family, or communities are a tool to observe reality (Alligood, 2014; Figueiredo & Martins, 2009). However, in more recent models, there is a perspective of the nursing care reality focused on family as a client. Nevertheless, there is not a model and/or theory that allows describing, explaining, predicting, or prescribing the nursing care focused on the community as a client (Alligood, 2014; Figueiredo & Martins, 2009). Moreover, the anal-

ysis of evidence of the practices of nurses in a community context identifies a practice primarily focused on individuals, families, risk groups, or environmental health (Poulton, 2009; Silva, Cubas, Fedalto, Silva, & Lima, 2010) and not, once more, on the community as care target. Thus, there is a lack of nursing models that shape the practice of nurses aimed at the community as a healthcare target, and, therefore, the need to develop them.

Following the above mentioned, it is common belief that the nurse should have an intentional action in the nursing process, when the community is the care target, that promotes the CE and allows the nurse to assess the process and the outcome of their clinical decisions, from the nursing diagnosis to the assessment of results. Within the scope of clinical decision-making in the nursing process, Figueiredo (2012) suggests the nurse's decision-making to be planned from diagnosis to intervention, based on an attention area or main focus and its diagnosis dimensions, according to previously defined criteria, so that interventions emerge as answers to diagnosis (main focus) and sub-diagnoses (diagnosis dimensions).

This study corresponds to a stage in a broader study whose purpose was to develop a nursing care model oriented to the community as a care unit, the evaluation, intervention, and community empowerment model (Melo, 2016), to be precise. In this stage, the goal was to identify whether there are foci in the community nursing that fit the dimensions of the community empowerment continuous model proposed by Laverack (2005) based on the clinical decision-making process proposed by Figueiredo (2012).

This study considers the CE both as a process and a result, consensually associated by the authors with cohesion, participation of members of a community, and its ability to identify and solve its problems (Israel et al., 1994; Marion, Labonté, & Laverack, 2002; Rappaport, 1981). The CE is also considered a central element associated with a structuring skill of the EEEC, whose practice is community-oriented. To fulfill our general objective of developing a nursing model that shapes the nurses' practice towards the community as a client, the CE continuous model of Laverack (2005) is employed as a framework, identified by evidence as a model that consolidated the CE approach as a result of an organized process of community intervention (De Vos et al., 2009; Kasmel & Andersen, 2011).

Research Question

Which are the attention foci in nursing, oriented towards the community as a client, that fit each one of the five domains of the community empowerment continuous model?

Methodology

This study is part of a constructivist paradigm, oriented towards the construction of knowledge based on reality/realities, whose sources are the actors who develop the practice associated with the discipline. Thus, a qualitative study was conducted with the use of the focus groups' technique (Temido et al., 2015; Kinalski et al., 2017).

The research question resulted in a structured thematic guide, which allowed the freedom of expression and the co-construction of results based on the discussion and interaction between participants. The process of organization and systematization of the focus group was carried out from the preparation of the thematic guide to the selection of the number of participants, duration and structuring of sessions (Temido et al., 2015; Kinalski et al., 2017).

The guide was organized in three thematic sessions, as shown in Figure 1, which introduces the main issue relating to Session 2, which addressed the research stage presented in this article. It should be noted that a warm-up meeting was developed in the first session (Temido et al., 2015), where the CE concept and the community empowerment continuous model, which was used as a framework for this study, in order to facilitate the discussion in the three sessions of issues related to the study's objectives, planned in a sequential way.

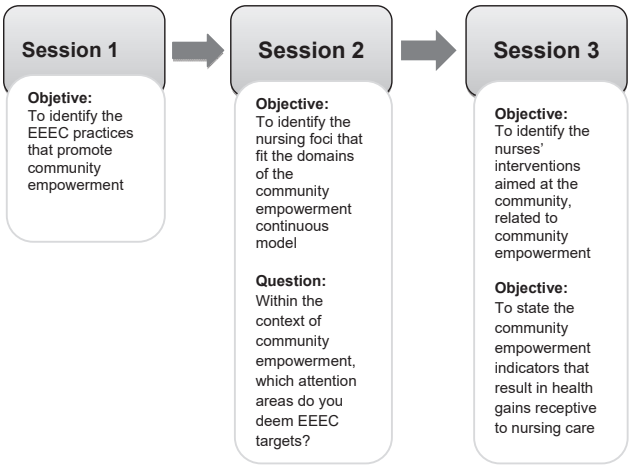

Figure 1. Organization of focus group sessions, in accordance with the study's objectives.

The selection of participants for the focus group obeyed the following inclusion criteria: a) being a Nurse Specialist in Community Nursing or Public Health in Portugal; b) exercising functions in a community care unit; (c) or in a public health unit (which both have the populations or communities as target population).

The selection of participants was intentional. The invitation to participate in our study was sent to Nurse Specialists in Community Nursing or Public Health, of five community care units and three public health units of the northern region of Portugal, indicating that the participation would be as individual experts, who fulfill the previously established criteria, in order to amount to eight participants, as suggested by the authors, as the ideal sample size for a focus group (Kinalski et al., 2016; Temido et al., 2015).

After the participants were gathered, three focus group sessions were scheduled, which took place at the premises of the Interdisciplinary Health Research Center of the Universidade Católica Portuguesa, in accordance with the consensual availability of all participants, as they were informed that more sessions might be needed throughout the duration of the project. The sessions had the duration of 120 minutes each, with a coffee break provided by the researcher. It was decided that the sessions would be undertaken by the principal researcher, with the support of a researcher collaborator who would take annotations throughout the session. The sessions were recorded on audio and video format to facilitate the subsequent transcription of the sessions, and all participants signed the informed study participation consent in the first session.

In relation to the ethical and legal considerations, this study was submitted for assessment and approved by the Ethics Committee of the Health Sciences Institute of the Universidade Católica Portuguesa (Opinion 14/11/2012 EC-ICS).

For the collection of data relating to Session 2, described in this article, participants were asked, based on the community empowerment concept discussed in the warm-up session, and their practices in the context of their professional, and taking into account the community as a client, to identify the attention areas they consider to be associated with community empowerment, in which they could mention the foci of the International Classification for Nursing Practice (CIPE), or state in their own words what they considered to be attention areas.

The content analysis used the technique described by Bardin (2015), following the methodological approach proposed by Bowling (2014).

The categories system was established with deductive procedures, based on the theoretical framework (dimensions of the community empowerment continuous model), to which we attached keywords based on the concepts proposed by Laverack (2005) and a code to each of the model dimensions (Table 1).

Table 1
Code for Community empowerment dimensions and keyword description

Community empowerment dimensions	Keywords	Code
Personal action	Internal power Leadership	PA
Organizer groups	Control Sharing Guidance Negotiation	OG
Communitarian organizations	Formal groups Link to external groups	CO
Partnerships	Social networks Resources sharing	P
Political and social action	Social changes Economic changes Involvement of people and organizations	PSA

The analysis of the data relating to attention foci used the exact same terms employed by the CIPE, version 2.0 (Conselho Internacional de Enfermeiros, 2011) or, when not the same, a consensual decision was made as to which CIPE term fit the description best. The analysis of information relating to nursing foci used basic concepts inherent in the nursing process methodology and in the nursing phenomena classification, actions and results according to the CIPE terminology, including in clinical decision-making the existence of the main attention foci and diagnosis dimensions (which may be themselves also CIPE-classified foci), that shape the main focus, according to the diagnostic criteria defined for each one (Figueiredo, 2012). Thus, foci associated with the community were identified using CIPE, and a table was created, like the one described above, stating the keywords associated with the definitions of each focus described in the CIPE and assigning a code to each one of the foci (Table 2).

Table 2
Code for attention foci related to the community and keyword description

Foci	Keywords	Code
Community leadership	Influence; management; leaders; conflict management; objectives	CL
Community management	Manage; control; regulate; accomplish/intervene; involvement of all participants	CM
Community process	Interaction; relationship	CP
Communitarian participation	Involvement	Com Part

After a categories classification table was created, including the community empowerment continuous model and the CIPE foci associated with the community as a client, a contingencies table was developed, linking the keywords and codes of Table 1 with the keywords and codes of Table 2, resulting in Table 3, which associates the codes for each of the tables that have keywords with common meaning.

Table 3

Analysis of the relation between foci keywords associated with the community and keywords of Community empowerment dimensions

Dimension code \ Focus Code	CL	CM	CP	Com Part
PA	x	x		
OG		x	x	x
CO		x	x	x
P		x	x	x
PSA		x		

The construction of this *a priori* categories system has allowed identifying the attention focus which would potentially become a main focus, according to the clinical decision-making system proposed by Figueiredo (2012), as well as which would be the foci that could constitute diagnosis dimensions.

The focus community management, regarding control, regulation and intervention related to the problems identified in the community, has a cross-cut relationship with all community empowerment dimensions, involving the application of individual leadership, as an influence for change, a catalyst of creation of small groups, organizations, partnerships, and a social and political action, thus becoming a main focus of clinical decision-making. The focus community leadership, associated with the Cognitive and Attitudinal dimension, which allows the influence and volition, relates to the personal action of the community empowerment continuous model. The foci community process and community participation, associated with the interaction of community members, relate to the community empowerment dimensions associated with the organizer groups, community organizations, and partnerships. Therefore, these three foci were coded *a priori* as diagnosis dimensions of the focus community management, as a result of the analysis of its relation to the dimensions of our reference model; therefore, the content analysis to be developed is focused on these three foci, since these would always be part of the focus community management.

After completing the categorization deductive process, based on the relation between the Community Empowerment Continuous Model, the CIPE foci, and the Clinical Decision-Making Process proposed by Figueiredo (2012), a final table (Table 4) is set up with the categories (the foci identified as diagnosis dimensions) and the subcategories (the keywords of each focus) which guided the analysis of the transcribed texts of the focus group recordings.

Table 4

Pre-established categories and subcategories system

Category	Subcategory
Community leadership	Leadership
	Influence
	Volition
Community process	Interaction/Relationship/Coping
Community participation	Involvement/Volition

This encoding *a priori* was validated by two researchers involved in this work, both experts in the nursing community.

Results

Eight nurse specialists participated in the study, three working in public health units and five in community care units, all exceeding 10 years of professional practice as nurses and 5 years as EEEC or Public Health, while active for 3 or more years in the mentioned functional units.

Based on the analysis of the transcribed texts of the focus group recordings, the registration units associated with each one of the subcategories for each category were calculated, and the results were identified, as shown in Table 5.

Table 5
Nursing foci within the context of Community Management and number of registration units

Category	Subcategory	No.
Community leadership	Leadership	20
	Influence	4
	Volition	3
Community process	Interaction/Relationship/Coping	78
Community participation	Involvement/Volition	81
TOTAL		186

As regards the community leadership, the analysis of the nurses' speeches identified, within the scope of the focus community leadership, 27 registration units. It is evidently important to identify the community leader: "It is important to know who the leader is . . . It is sometimes unnoticed. The leader is not always that who was appointed as such." (EE1, December 2014). It is also extremely important to identify the influence of this change leader, even if they are not the formal community leader: "I usually identify the leader of the group and try to analyze how this person affects others in a positive way . . . I also assess if I am faced with a community with leadership or not" (EE9, December 2014). Within the context of leadership, the leadership skills of the community leader are also valued: "In schools, the PES teacher [responsible for the health education program] should be the Leader, but they are not always prepared to lead." (EE3, December 2014). The motivation and volition of the leader for the project are also mentioned in the nurses' speeches when it relates to community leadership as an attention area of nurses: "Sometimes we plan a project, but if the leader does not want to change, we have trouble approaching the community" (EE6, December 2014).

The nurses' speeches also emphasized leadership perspectives focused on the external agent to the community:

> In fact, the leader has to be the USP [public healthcare unit] professional, since they are who possess the skills to develop the health planning and therefore to lead. In the USP, our attention areas are all, but we confirm that the community has to be motivated. I do not know if motivation is leadership. (EE2, December 2014)

A concern was also evident regarding the volition of the community members, besides the leader, when the nurses refer to community leadership: "When I wanted to develop the project of oral health, I realized it was important to evaluate the educators' attitudes relating to brushing, that is, the willingness to participate in the project based on these attitudes." (EE4, December 2014).

As regards the community process, 78 registration units were identified in association with the focus community process. A concern with the interactions and relationships is evident in the speeches, as they promote the adaptation and development of forces and resources (coping)

between the community members as attention areas of nurses: "It is important to assess how the different school individuals relate and strengthen themselves before attempting to implement whatever." (EE1, December 2014); "When I tried to implement brushing in a kindergarten, I realized I would not achieve anything because the teachers and assistants disagreed with each other and neither had resources to even think about pursuing this project. I had to solve this first!" (EE4, December 2014); "It is more difficult to approach the community and make some members understand each other and realize that together they are capable of doing so, rather having worked on the project indicators." (EE8, December 2014).

As regards the attention area community participation, 81 registration units were calculated. In this category, statements associated with the involvement of both members of the Community were identified, either from the community leader, in which the nurses identify the communication, organizational structures, and partnerships as influence factors of the involvement of all community elements in the planning of projects to achieve results: "The involvement of school health teams and education professionals is essential to meet the indicators." (EE5, January 2015); "A way to promote the community participation is addressing the way they communicate and organize themselves. If there are conflicts between assistants and educators, or sometimes with the management of the kindergarten, nothing is achieved" (EE7, January 2015); "Organizing the involvement of more organized structures, such as parents' associations or class committees, can help people to participate." (EE9, January 2015); "A way to achieve the community participation is through the partnerships . . . All working towards the same goal, each with their own resources." (EE9, January 2015).

The community participation is the category with a greater number of registration units (81), followed by the community process (78) and the community leadership, with 27.

Discussion

The relation between the registration units and the categories and subcategories identified in the *a priori* categorization process revealed the community management as a main focus, thus fulfilling the continuous development of the EC from the personal action to the social and political action, as a result of identifying the relation of its definition in the CIPE to the definitions of all the dimensions of the continuous model proposed by Laverack (2005). For the focus community management, the diagnosis dimensions were the foci Community participation, Community leadership, and Community process, identified by the analysis of the data revealed by the focus group.

Both the community process, a focus associated with the interaction of community members, and the community participation, associated with the involvement of communities derive from the interaction with the internal system and other community subsystems, possibly occurring thus in a wider microsystemic context, with small organizer groups, or in a more mesosystemic panorama, at the level of community organizations and partnerships. The community leadership, as a nursing focus, establishes a close relation to the personal action in order to promote a sense of inner power in individuals of a community, allowing them, once empowered, to form small groups, community organizations and to commit to partnerships consolidated in social and political action, considering the objectives defined to address the problems of the community (Laverack, 2005).

This study is limited by the fact that the results emerge from the perceptions of a limited group of nurses who work in contexts where the community is potentially a care unit but confined to the northern region of Portugal. Therefore, a next step in the larger study developed the validation of the clinical decision-making model, including the attention foci presented in this study, by means of a Delphi panel with the population of Portuguese nurse specialists in community nursing, whose consensus allowed to validate the designated model of assessment, intervention, and community empowerment.

Conclusion

This study aimed to identify the attention foci of nurses, who fit the CE dimensions and promote a community approach as a care client.

The identification of these attention areas can

help to promote a clinical decision-making focused on the nursing process with the purpose of empowering communities, based on community health nursing care.

To conclude, the nurse's approach to the community as a client is based on a main focus, community management, with three diagnosis dimensions: Community participation, Community leadership, and Community process, associated with the concepts stated in the CE model which this study used as a reference. The nurses' speeches are therefore consistent with the meaning suggested by Laverack for the CE dimensions, which can be part of the nurses' clinical decision-making as a process and a result, since they associate with nursing foci described in the CIPE for the community as a client.

One can also conclude that the skills provided to the nurse specialist in nursing community suit an approach of the attention areas already identified, which are included in the competence of community empowerment. However, depending on the organizational and political context of the community nursing care, the attention focus and its diagnosis dimensions identified in this study may be the target of diagnosis by other nurses who are not specialized in community nursing.

This study is socially relevant, as it frames in an objective manner the contribution of nurses as active agents in the promotion of the CE as a process and as a result. If nursing care is the care to the person without firmness, when one speaks of the collective of people and in the weakened community, one speaks of a political and social system without firmness. The system is the people, therefore the CE as a part of the decision-making process of nurses is a noble way of giving firmness to the social and political system, promoting the health of populations and the exercise of citizenship.

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